Call Handling Tips for Maximising Risk Identification in SRH

This document is designed for Clinical Leads, GPs and Nurse Practitioners, SHAs and training staff unused to conducting tele health consultations in SRH environment.

The aim is to focus on call flow required to maximise opportunities to illicit those at most "risk", safeguarding identification etc. Feedback to professional bodies reflects concerns that these may be being missed in the tele health platforms.

Each service will have differing requirements dependent on skill mix, previous digital experience etc. For most SRH clinical staff existing skills with a framework for escalation will require minimum changes to practice.

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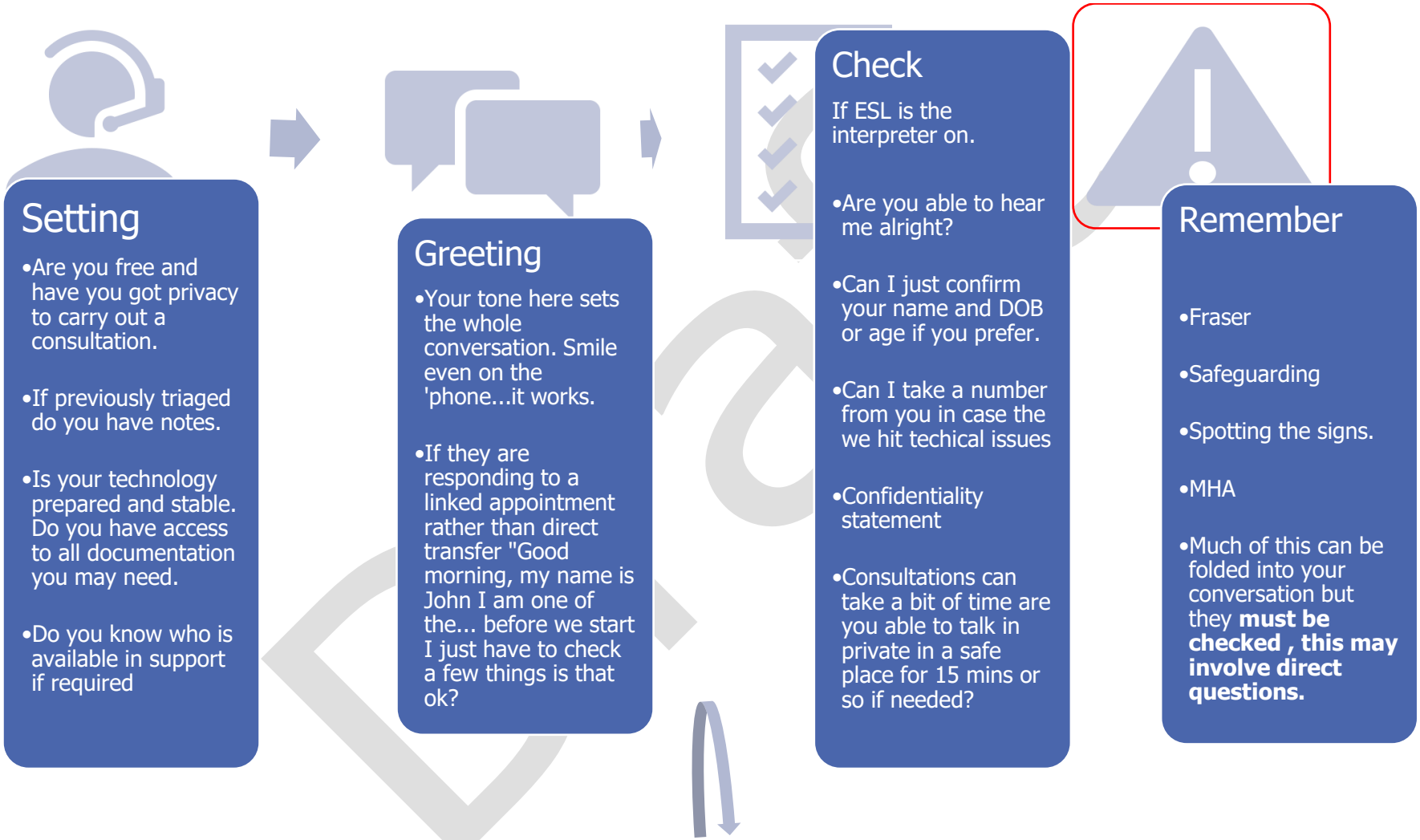

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Setting Top Tips

Taking a few minutes between calls to set yourself up makes all the difference to the way you enter a call, if you are trying to battle technology, answer e-mails or multi task it quickly becomes apparent on the call, and you may miss subtle references.

Use a proper headset if possible, often speaker phones can sound very concerning to callers as they worry about being overheard and it lets you be handsfree.

If an interpreter has been arranged, are they available and clear of their role before starting?

If using video make sure you are lined up for proper eye contact and resist typing and looking away at your keyboard, if you are going to then say to the caller *"I just have to check something",* so they are included and not ignored.

Blur your background on video, particularly if working from home.

Try and have guidance documents already open, just in case you need them, so it's a mouse click rather than an internet search. Local, FRSH and BASHH. [1]https://www.bashh.org/guidelines [2]https://www.fsrh.org/standards-and-guidance/[3]http://ukmec.pagelizard.com/2016

Make sure you know who a support or senior escalation point is for clinical advice or safeguarding, particularly live incidents. When talking with people in their own homes you are much more likely to become a party to domestic incidents and live suicide threats or attempts, you cannot deal with the caller and get emergency services at the same time.

[1] British Association of Sexual Health & HIV
[2] Faculty of Sexual & Reproductive Health
[3] UKMEC UK Medical Eligibility Criteria for Contraception

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Greetings and Checks Top Tips

If you have an interpreter on call get them to introduce themselves first and explain their role, if a family member is acting as interpreter you must consider if this is appropriate for the type of consultation. If not end the call explaining why and offer independent support.

The mode of entry into the conversation shapes your greeting, if it is a pre booked appointment or a direct in call either way you start by introducing yourself. If a direct in call it maybe that you introduce yourself with a title *"Good morning you are through the city clinic, you are speaking with John, I am one of the nurses here how can I help?"* or if pre booked *"Good morning my name is John I am one of the nurses here, can I just check that I have the right person on the call, could you tell me your name and DOB or age."*

All this should be said with a smile, even on the 'phone! It does work.

Try to strike a conversational tone by adding pre curser statements " *So before we crack on can I just check, can you hear me ok? And just in case is there a number I can call you back on if tech falls over?*

Confidentiality Statements must always be given before any discussion takes place and you must document having done this. Each service has its own version of language but keep it simple and in plain English.

"We are always confidential here whether on the phone or in person, except if we think there is a risk of you or someone else being hurt or put at risk, but we will always try to discuss these concerns with you and work with you before doing anything else."

Once confidentiality statement is read again a softening statement gets you back on flow

"Great now the consultation can take a bit of time are you free to talk and able to answer questions without being overheard?"

If you have your own local checklist for "risk" have it to hand but make sure it is available on all consultations, some calls can quickly run off course and you are off the call before you realise you missed something.

Brook has a CORE form 20200130 CCR Form inc Sexual History GM as an example, with thanks to Louise Carrington Director of Operations Brook for sharing.

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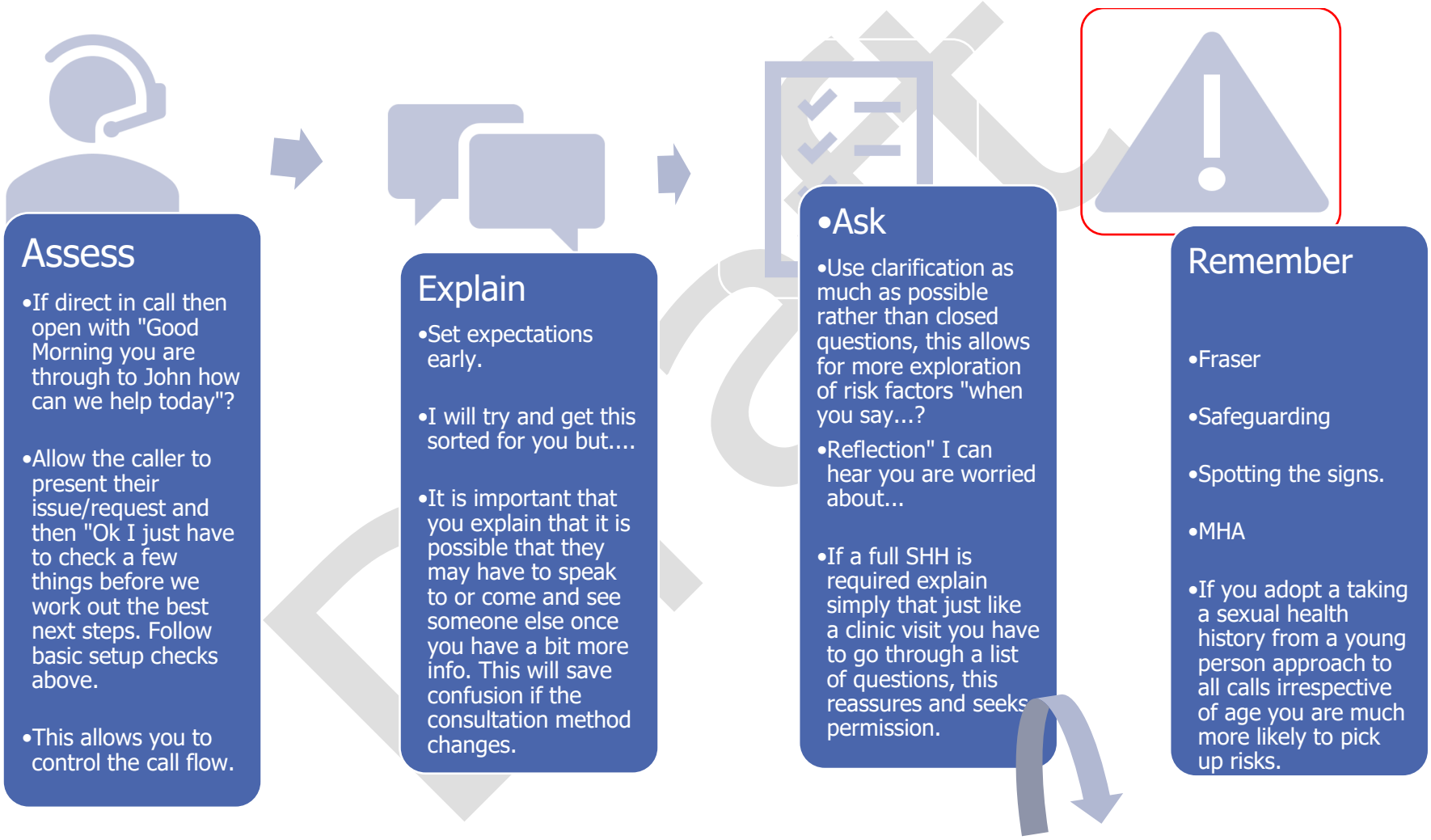

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Body of the Chat Top Tips

Acknowledge that you have heard what they are calling about "So you had UPSI and want emergency contraception? Yes? Ok, well I have to go through a few things with you and then I might have to see if one of our prescribers is available or get you in to see someone depending on the route we go. Is that alright?"

You have set expectations of possible transfer early on, this prevents friction later, if someone has spent time answering your questions and think they are finished and then have to be re-routed that is when you get reactions, manage it before it happens.

You have also explained that there will need to be more questions as there is more than one possible outcome, this is "seeking permission" something you have to do a lot more directly than when face to face without non-verbal comms, nods etc.

Using FRAMES behavioural change and MI techniques but stripped back to basics using a mix of reflection and clarification language. see case example at end, explore all possible issues and solutions.

- EC Options and Choices (Be aware of capacity issues, don't offer what you can't provide, IUD.)
- Consent (Fraser, MHA and coercion)
- STI risk and assess (Offer testing in timeframes and by most appropriate method if required)
- Onward contraception or adjusting advice if Ulipristal and on COC. (Quick start and script considerations)

Bearing in mind the caller just wants a pill probably, that is why "seeking permission" before starting is so important, you have to have the conversations they haven't even considered.

If you are taking a full sexual history then it is best to present this as just what it is "*In order to make sure we cover everything there is a list of questions we need to go through to make sure you get the right plan going forward, we do this with everyone so they are generic ,some may apply to you and others won't but we have to ask them all. Is that ok?"*

Again "seeking permission" at every step, it keeps the person centred focus in the absence of non-verbal comms.

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Ask Yourself

- Is there anything I have heard so far either content or demeanour that has made me consider this person requires escalation either clinical or risk.
- Do I need more information to progress this call.
- What is the gold standard for this type of presentation? Can I provide it and if not, is it available via another route?

Explain

- *"Because of what we have discussed I think the next steps that would help you would be."*
- List them in detail for e.g.
- *We can provide test kits that you can pick up from.. and then do at home, you then return that to...we will have the results in by...So if we set up another call on...to discuss the steps after that, would that be ok?*

Ask

Is that OK for you

Are you able to do this?

Explore Understanding and any barriers.

" I need a lift to clinic and don't want to ask my....I would have to ask twice, can't I just do the test there? or "Can't you just give me something?"

If the answer is No then what is your alternative?

Postal/Local pick up

Remember

Appropriate next steps list should always include if relevant.

Abstinence message if suspected STI

Ongoing contraception safe sex message

Full walk in to online PIL and expanded information if required.

PN discussion if diagnosed.

A clear agreed next steps plan reiterated

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Working in Partnership

Dependent on your role or things you have heard you may at this point decide you require to move this to F2F, under 16 for example. Or to seek some senior support if unsure. Don't be afraid to own that, be honest. *"I think because of your circumstances I might have to get you in to see someone, but can you give me a minute to check with one of my colleagues, I want to see if they agree and how we could make that work for you? Or do you want me to call you back in 5 mins, would that be better?"*

Do not feel pushed beyond your competency or instinct, some callers can be very rushed in their delivery and that can make you feel you have to match their pace, when faced with this you need to take control of the call, you can do this by simply *saying "I understand how frustrating all these questions are but I can't be sure we have covered everything we need to help you unless I ask them."* And then reset the pace.

The anonymity of a call can work for you and against you, some callers are much more forthcoming about details if they are not in front of you but this can lead to over sharing, by that I mean you get the whole saga of their relationships past and present before they even get close to telling you why they called. To manage this in the least abrupt way possible use polite but relevant interruption to re-focus. *"Sorry can I just ask, just so I don't lose track, when you split with the ex who was cheating and started with this new guy did you have an STI check before staring a sexual relationship with the new partner?" So how long ago did all this happen? And you have symptoms now? OK, with either of these partners was there any sexual contact without condoms?* So, although you are stopping them it sounds as if you are listening and responding.

If you are recommending an action to someone you should always explain why *"I would like to get a test kit to you because you have symptoms, but many STI's can produce similar symptoms so we have to test to make sure firstly it is an infection and if so which one it is so you get the right medication, antibiotics need to be tailored to any infection you may have or we will just be back here in a few weeks."* As people have often self-diagnosed either from Google or from past experience prior to speaking to you, they will just want treatment, as you are not giving them what they might expect then explaining why you are doing it diffuses possible breakdown in the consultation.

Make sure you have covered everything you want to in terms of next steps and have fully explained them and have the contacts agreement.

Provide post consultation resources so electronic PIL of choice or website https://www.sexwise.fpa.org.uk/ or https://www.brook.org.uk/help-advice/ for e.g.

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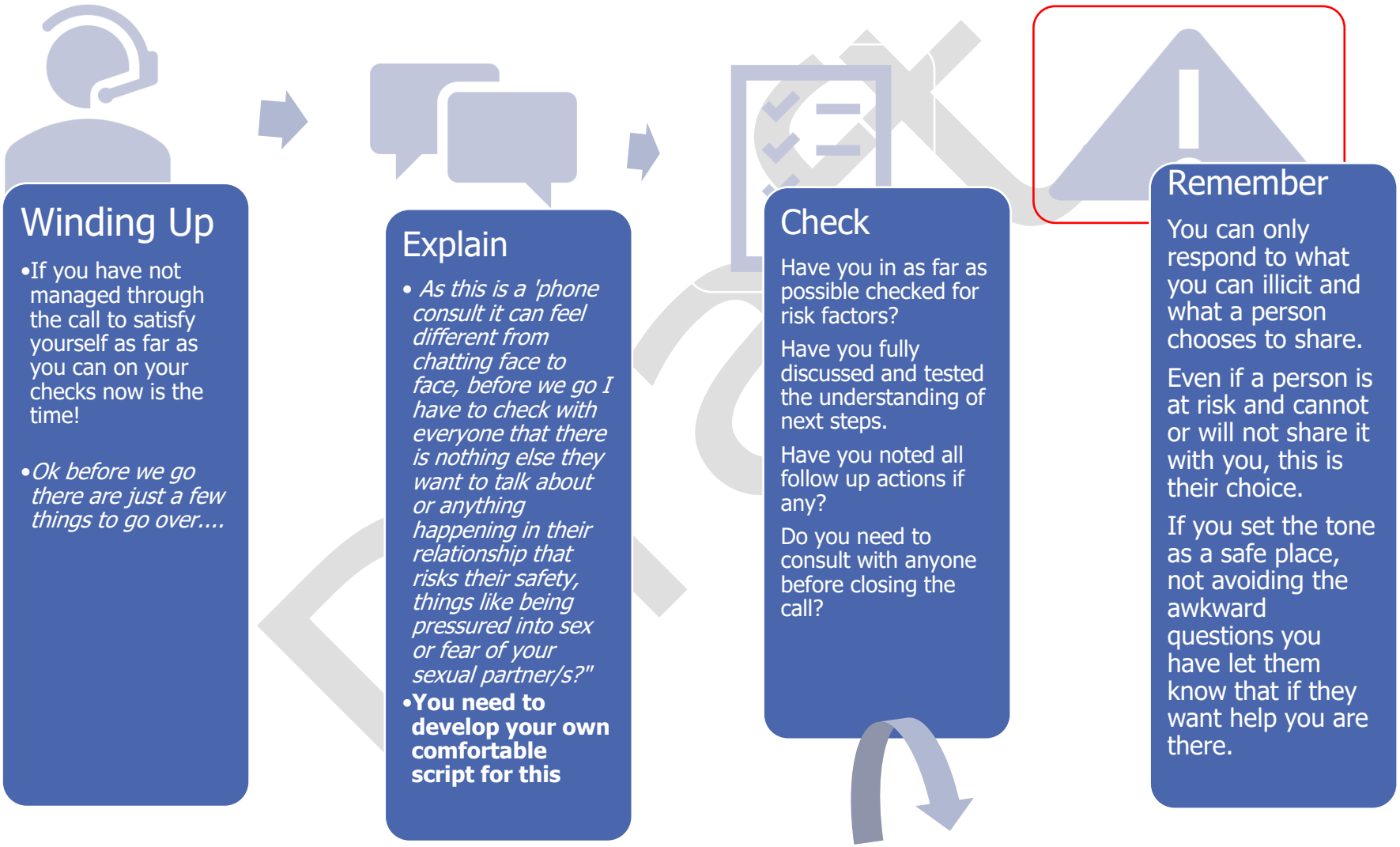

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Closing Out

If you have managed to satisfy yourself that there are no obvious risks presenting then having clarified next steps thank the contact and end the call.

If you have not managed to either fold in the questions during taking a history or had no opportunity you must ask them somehow. A simple statement *"As this is a 'phone consult it can feel different from chatting face to face, before we go I have to check with everyone that there is nothing else they want to talk about or anything happening in their relationship that risks their safety, things like being pressured into sex or fear of your sexual partner/s?"* This is the same with video consultation. If no issues raised.

Then close out with "*Great so you will get your brother to run you to the local GP tomorrow and we will organise to have a test kit there for you to pick up and then if you post it tomorrow afternoon we should have the results on Thursday morning and I will call you at 2pm on Thursday afternoon I will send you a text reminder. If your symptoms become worse in the meantime….*"

If issues raised follow your local procedure and escalate in accordance.

Immediately after call do all action items immediately , order kits, book appointments, send out reminders and complete documentation. At any point a consultation can go into crisis so doing your post call work before starting another consultation prevents errors if subsequent plans go awry.

Be kind to yourself, you can only deal with what is presented to you, if you create a safe and comfortable environment for conversation then you have done all you can to identify risks. What most people need to disclose is a sense of safety.

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Case Study: From National Helpline purely onward signpost.

Female caller wanting to know where to get "the morning after pill". Her local clinic is closed because of COVID. "That's where I normally get it, but I had to buy it from Asda pharmacy last week and it cost a fortune, I don't have enough money to buy it again." On discussion with the adviser the client reports that she can't go to her GP as she "has already got it once from there this week". "It's so embarrassing…and the nurse has to call you back, but you don't know when and you can't always answer in the house as my mum could hear and she will go nuts that I've been having sex outside and seeing my boyfriend as we are supposed to be in lockdown cause my brother has asthma."

Following the call flow below the adviser ascertained that the client was 15, as was her boyfriend, it was reported that neither of them had any previous sexual contact including oral sex. Adviser found the contact number of the local hub triage and explained the process. A discussion was then had about condom use and the problems her boyfriend had using them. Adviser explained different fits were available and she should discuss this with the clinic when she got through, this led onto a wider discussion on contraceptive choices, the adviser reassured the client that it was "safe" to discuss contraception with the clinic, even under 16, explaining the role of the clinic. In order to reinforce the safe sex message and understanding she walked the client into the relevant sections of the Brook website and suggested she and her boyfriend explore it together. A discussion was also had about "sex outdoors and safety." This allowed adviser to assess understanding and consent, adviser also acknowledged the risks of any close contact outside the family group as a risk to her brother re covid-19. The young woman was invited to call back if she had any difficulty accessing service or wanted to discuss anything further.

Take Aways:

Time to do the complete discussion

Don't just respond to the question.

Think Package: Pregnancy test, condoms, STI Testing Kit, POP further broader sexual health and wellbeing advice and safeguarding check .

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Soft Welcome

Provide a full salutation:

"Good Morning, you are through to the .....generic line, how can we help?"

This gives the client time to collect their thoughts after a lengthy hold or sudden connection. Remember we only have our voice to convey "a safe space".

ASK

- Is it alright to ask you some questions so I can make sure you get the right support?
- Can I ask your age?
- Are you able to answer without being overheard?
- When was the UPSI?
- Are you using any regular contraception?
- Is this a new sexual partner?
- Have either of you had previous sexual partners?
- Have you both had a recent STI test?

Assist

- If not able to talk ask if they can go somewhere more private and call back?
- **Under 16 escalate !**
- If they say they are unable to secure privacy, ask if they are safe?
- Consider time frames and best options avaialble.
- Consider EC impact on exsisting contraception.
- Discuss ongoing contraception options, free condoms.
- Suggest testing kits if appropriate. STI and Pregnancy.
- Test consent

ACT

Has anything been said or have you noticed hesitancy or reluctance?

You must consider whether a longer discussion either with a senior or face to face is required to ensure safeguarding responsibilities are fulfilled.

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Call Handling Skills to Maximise Opportunity to Identify Risk.

Remote consultations only require very modest adaptations of our existing skills using existing protocols, however consideration must be given to individual comfort with communicating without our "usual tools". Having a bit of chat on the way into a consultation room to ease tension, being able to see the persons demeanour, anxiety levels, distress or understanding of information is all part of the normal assessment, for many practitioners the loss of these guides will be intimidating and could shake self-confidence. For any triage of vulnerable groups to work the emphasis on "usability" for the service user must be the focus.

Fear of "missing something" is a common concern for staff , however 'phone consultations have advantages if set up properly.

- The "anonymity" some callers feel may make them more forth coming.
- You can easily change this to a F2F if you feel it is necessary, so you don't feel pressure to "solve" everything.

Scripts were considered to aid in this, however the sheer variety of possible presentations makes this impossible, instead ways of communicating that let you "hear" certain alerts and guide you to explore were seen as the way forward, use of existing checklists for safeguarding should provide the template. Doing our job without the non-verbal skills we all use is the most difficult part of adapting our communication styles to maximise engagement.

The key differences are:

- They can't see you smile as you welcome them from reception. But they can hear it! Your tone is everything as is pace, if you sound harassed and busy when you "welcome" someone, you are more likely to get brief incomplete information from questions and miss risk.

  "Good morning…My name is Jo, I am one of the health advisers. .how can I help you today."

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- The National Helpline uses an adaptation of **FRAMES** (Miller, 1994) model to keep control and flow of the call and the grids system to ensure certain questions are "folded" in to explore consent, coercion etc. For experienced SRH staff going back to these basics will help ensure all that can be asked is asked.

FRAMES

Six elements have been identified that were present in brief intervention clinical trials, and the acronym FRAMES was coined to summarize them (Miller and Sanchez, 1994). This has been adapted for internal call handling purposes.

Explanation of (adapted) FRAMES Approach

Feedback – listening to how service user's present – what is their story and how are they feeling? *Advisers start to assess the areas of concern.*

Reason – using a balanced combination of open and closed questions to narrow down core areas of concern.

Advice – using the information collected, and awareness of the service limitations, advisers will understand what concerns are primary (can be addressed within tele environment) and what are secondary concerns (signposting, escalation safeguarding.). Deliver tailored information.

Menus – prior to giving recommended next steps, assess the following:

Does the service user require further discussion to fully understand their needs or options , F2F or emergency response

Has the service user's emotional state become worse – F2F, or emergency response

Does the service user require vulnerable person enhanced engagement/ F2F

Offer appropriate national signpost for PIL alternatives https://www.brook.org.uk/ or https://www.sexwise.fpa.org.uk/

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Empathy – where advisers' information and support guides service user towards next steps, advisers' tone, and language guides service user towards emotional stability

Self-efficacy – check service user's understanding of next steps (i.e. understanding of local service, are they motivated to use signpost '(buy in') summarise the call.

Menu's Section: Is the most important area to concentrate effort on as this is where you are most likely in a telephone consultation to pick up hidden concerns, there are limitations but this is the best chance to pick up vulnerabilities "When you say you are having sex outside…..?"

However, if we haven't got the Feedback right which demonstrates reflection of the callers concerns or the *Empathy* which is our tone and creates a "safe space" then we are unlikely to be able to provide complete tailored Advice or get buy in on *Menus*.

Self-efficacy section gives you an opportunity to recap and check understanding of next steps as well as promote safer sex and behaviour change. Always provide a signpost for caller to look at after discussion to ensure the reinforcing of key messages.